



Nursing Facility Bed Tax Quarterly Report

15-60-101, MCA

Quarter ending _____/_____/_____

Federal ID # _____

Name and
address
of Nursing
Facility

a.	b.	c.	d.	e.	f.
Bed Days Available	Bed Days Occupied	Bed Days Medicaid	Bed Days Medicare	Bed Days Other	Bed Days Private Pay

1. First Month _____

2. Second Month _____

3. Third Month _____

4. Quarter Total _____

5. Total bed days subject to tax (Total line 4 column b)
Column b must equal total of Columns c, d, e, and f

6. Total Tax (line 5 X \$4.50)

7. Adjustments (explain on back of form)

8. Penalty and interest

9. Total tax remitted (Lines 6 + 7 + 8)

Revenue Account Code **503001**

Date

Signature of Preparer

Print Name

Phone No.

Retain a copy for audit purposes. Statement and remittance for any tax due must be **received** on or before the 30th day following the end of each calendar. If you have any questions, please contact our Customer Service Center at:

Montana Department of Revenue
P.O. Box 5835
Helena, MT 59604
(406) 444-6900